

DRC INTEGRATED HIV/AIDS PROJECT

PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC) YEAR 4 QUARTERLY REPORT, QUARTER 1

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
APS	
ART	antiretroviral therapy
ARV	antiretroviral medication
ASF	Association de Santé Familiale (Association of Family Health)
C2C	child-to-child
C-Change	Communication for Change
CDC	United States Centers for Disease Control and Prevention
CPCC	Champion Community Steering Committee
CSW	commercial sex worker
DIVAS	Division des Affaires Sociales (Division of Social Affairs)
DIVGFE	
DRC	Democratic Republic of Congo
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FFP	Fondation Femme Plus
FY	Fiscal Year
GBV	gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV counseling and testing
HGR	Hôpital Général de Référence (General Referral Hospital)
HIV	human immunodeficiency virus
IR	Intermediate Result
ITN	insecticide-treated net
LIFT	Livelihoods and Food Security Technical Assistance
M&E	monitoring and evaluation
MARP	most-at-risk population
MINAS	Ministère des Affaires Sociales (Ministry of Social Affairs)
MOH	Ministry of Health
MSM	men who have sex with men
NACS	nutrition assessment, counseling, and support
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PBF	Performance-Based Financing
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PICT	provider-initiated counseling and testing
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission of HIV
PNLS	Programme National de Lutte contre le SIDA (National HIV/AIDS Program)
PNMLS	Programme Nationale Multi-Sectorielle de Lutte contre le SIDA (National Multisector Program for the Fight Against AIDS)

PNSR	Programme National de Santé de la Reproduction (National Program for Reproductive Health)
ProVIC	Projet Intégré de VIH/SIDA au Congo (Integrated HIV/AIDS Project)
PSI	Population Services International
QA/QI	quality assurance/quality improvement
RDQA	routine data quality assurance
RECO	
RNOAC	Réseau National des Organisations d'Assise Communautaire
SGBV	sexual and gender-based violence
SHG	self-help group
STI	sexually transmitted infection
SWAA	Society for Women and AIDS in Africa
TB	tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development
VSLA	Voluntary Savings and Loan Association
WHO	World Health Organization

EXECUTIVE SUMMARY

In the final weeks of Fiscal Year (FY) 2012, the *Projet Intégré de VIH/SIDA au Congo* (ProVIC) FY13 implementation in the Democratic Republic of Congo (DRC) was mapped out via a highly participative work-planning process which included multiple DRC government departments, United States Agency for International Development (USAID) staff, local grantee and international partners, and, importantly, spokespersons for people living with HIV/AIDS (PLWHA) to ensure that this plan genuinely prioritizes the needs of the PLWHA community. Emerging from this five-day consultative workshop was a consensus-built, ambitious 12-month work plan aligned with DRC government strategies and United States President's Emergency Plan for AIDS Relief guidance, including a new focus on integrating ProVIC's interventions with government health zone structures and planning processes.

Disseminating and validating this plan at the provincial and health zone levels began early in the first quarter (Q1) in Katanga, Bas-Congo, and Sud Kivu in two-day workshops involving all key health actors in each province as well as leaders from the health zones in which ProVIC operates. (Slight delays on the government side pushed the Province Orientale and Kinshasa validation into the start of Q2.) This improved coordination and communication with all levels of the health system will be further reinforced by ProVIC's participation in the health zone annual operational plan process in all 35 health zones where the project operates, which will occur throughout Q2.

The first quarter of FY13 also marked the more than doubling of ProVIC's local nongovernmental organization, private health facility, and public health zone and facility partners—from 35 local partners in FY12 to 94 partners in FY13 (59 of whose agreements are now in place). These 94 partners will include collaborative accords with 35 health zones.

This ProVIC FY13 Q1 report tracks workplan rollout and outlines key activities undertaken during the period October to December 2012; in particular, activities focused on ProVIC's key project Intermediate Results, which report on champion community prevention activities, HIV counseling and testing (HCT), prevention of mother-to-child transmission of HIV (PMTCT), sexual and gender-based violence (SGBV), care and support, and health systems strengthening.

Data presented in this report represent 91 percent of all Q1 M&E database datacards reported, uploaded, and sanitized to date. While the first quarter period of every project year (October through December) is typically a slower one—with offices and activities slowing for the winter holidays in mid-December—Q1 of Year 4 was nonetheless a highly productive period for ProVIC. At the end of Q1, for example, ProVIC had achieved more than 28 percent of its annual target for prevention messaging among most-at-risk populations (MARPs) and between 34 percent and 110 percent of most annual care and support targets—from economic strengthening activities and nutritional support to PLWHA prevention and clinical care. Low results reported for a few selected activities [e.g., GBV, tuberculosis (TB)] are generally due to the start-up period for these activities; local partners' interpretation of newly introduced project indicators and hence reporting for those indicators (for GBV); newly introduced data tracking tools (for TB); and data still being sanitized in ProVIC's M&E database at the time of report submission.

ProVIC HIV prevention work operates through champion communities. The focus for Year 4 is on consolidating existing champion communities for long-term sustainability, while adding new champion communities (particularly those focused on key populations) and priority health zones in Katanga where the epidemic is most intense. ProVIC is rebalancing its resources to meet these needs in Katanga, including by establishing two new champion communities in Lubumbashi and one in Luisha that is linked to an artisanal copper and cobalt mining site. This Luisha region has a high concentration of highly vulnerable populations that contribute to a rapid increase in HIV incidence, such as mobile commercial sex workers, truck drivers, and young male miners from throughout Katanga and Kasai who travel to the region in search of a livelihood.

HCT services continued in Q1, with an increased focus on provider-initiated counseling and testing and a reduction in mobile HCT to better target limited resources. SGBV service providers, now fully trained and equipped with post-exposure prophylaxis kits, received their first beneficiaries, while messaging in the community on GBV and available services continues. PIMA™ analyzers for CD4 count are now operational in 33 ProVIC-supported health facilities.

ProVIC continued its PMTCT leadership role by initiating four key innovative interventions to improve service quality for mothers and babies and strengthen community linkages. These included the Improvement Collaboratives quality assurance/quality improvement methodology, which will be introduced in four maternities in Kinshasa. ProVIC also launched its Mentor Mother approach, which will be piloted in six ProVIC-supported health facilities in Kinshasa, Katanga, and Kisangani. ProVIC also launched routine testing for syphilis and finalized the Performance-Based Financing methodology and training with government staff at all levels.

ProVIC's care and support work in Year 4 is focused on improving performance in tuberculosis (TB) screening and referrals, which remains a challenge due to ongoing sporadic stockouts of TB diagnostic supplies (to confirm TB in screened PLWHA) in TB centers. Equally, ProVIC is strengthening its integrated HIV/AIDS care services in health facilities by strengthening the capacity and internal care referrals of key health facility partners, starting with key "model" sites, such as *Hôpital Général de Référence* (HGR) Kenya in Katanga and HGR Bagira in Bukavu, which will become learning sites for ProVIC's other sites. The Luisha health center is now an antiretroviral therapy and PMTCT site, as the result of ProVIC advocacy with key DRC government leaders, new training, and technical inputs. This health center, linked to its population via a Champion Community, will provide integrated care and prevention services to a vulnerable population that previously received only sporadic, mobile services.

The key focus in FY13 of health systems strengthening is improved referrals and linkages between the spectrum of activities that make up the continuum of care within the champion communities. To achieve this improvement, a series of activities was undertaken to improve links between health facilities and community actors, such as shifting self-help group meetings to hospital grounds, as well as the formal establishment of a referral network and tools in Lubumbashi, adding to Bukavu and Matadi, which were previously launched. Nongovernmental organization (NGO) capacity-building activities were boosted with the hiring of an NGO Capacity-Building Specialist, who immediately set out to review and update administrative and financial manuals and policies to ensure adherence to USAID and DRC laws and regulations.

QUARTER 1 PROGRESS BY TECHNICAL COMPONENT

Intermediate Result 1: HIV counseling and testing and prevention services improved in target areas

Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened

Activities and achievements

Activity 1: Reinforce and expand access to prevention services for most-at-risk populations (MARPs) and other vulnerable groups. To reach MARPs, ProVIC trained 125 men who have sex with men (MSM) and commercial sex workers (CSWs) as HIV/AIDS peer educators. Each Champion Community established support sites that work with MSM and CSWs to promote HIV/AIDS education. From those sites, eight MSM and CSW networks were created to facilitate the organization of HIV/AIDS prevention activities specifically targeted at those populations. Activities conducted via the MSM/CSW networks included a range of social and behavior change communication outreach efforts as well as referral and linkage of HIV-positive MSM and CSWs to self-help groups (SHGs).

Projet Intégré de VIH/SIDA au Congo (ProVIC) mobilized Central Health Zone Bureaus, Champion Community Steering Committees (CPCCs), Relais Communitaires, and other key stakeholders to conduct risk and vulnerability mapping in champion communities with high HIV/AIDS prevalence. This allowed Champion Community mobilizers to better plan and coordinate activities targeted at MARPs. At the end of the mapping exercise, champion communities were able to (1) establish lists of vulnerable populations; (2) identify high-risk HIV practices and professions; (3) prioritize interventions; and (4) identify the most effective areas for MSM and CSW support sites.

Activity 2: Increase Champion Community access to information and knowledge on behavior change conducive of an increase in utilization of HIV/AIDS prevention and gender-based violence (GBV) services. ProVIC has provided technical support for the activities implemented by the 49 champion communities. To boost CPCCs, the project presented the new organization of the champion communities, and invited each Champion Community to pick the Champion Community model that will allow them to reinforce the participation of all community members.

In order to consolidate activities and utilize the risk and vulnerability map, CPCC members designed work plans for community action. These work plans allow ProVIC to better target specific populations during Champion Community awareness campaigns. A total of 46 work plans were developed and letters of engagement signed between the communities and the health zones, of the anticipated 49.

In response to strong encouragement from Programme Nationale Multi-Sectorielle de Lutte contre le SIDA (PNMLS) and Programme National de Lutte contre le SIDA (PNLS), ProVIC conducted activities in all five provinces for World AIDS Day, based on the theme "Objective Zero: Zero New HIV/AIDS Infections, Zero HIV/AIDS Related Deaths, Zero Stigmatization and Discrimination." All World AIDS Day activities began on December 1, 2012 and were conducted throughout the month. Highlighted activities included community dinners with people living with

HIV/AIDS (PLWHA) and orphans and vulnerable children (OVC) groups in several champion communities, awareness-raising campaigns using mobile cinema, and participation in/appearances on television and radio shows.

Activity 3: Improve youth access to HIV/AIDS prevention services. ProVIC held seven focus group discussions with youth in Mbakana, three in Mont Ngafula, and five in Biyela, Kinshasa, to better understand their needs. In Katanga, ProVIC worked with youth centers to establish peer education activities to promote abstinence, fidelity, and safe and responsible behavior. Specifically, ProVIC educated youth on proper condom use and distributed male and female condoms. The four youth centers (in Bas-Congo and Sud Kivu) and youth clubs established in Fiscal Year 2012 have continued to conduct HIV awareness campaigns through schools and youth associations, adapted to the needs of each target audience. In addition to normal activities, ProVIC took the opportunity to further reach youth by distributing condoms and conducting peer sexual health education at a concert supported by the United States embassy (Yebelampemibatela, by the Congolese singer Alash).

Overview of Q1 data

PEPFAR Indicator	Year 4 Annual Target	Year 4 Q1 Achievement						
		Bas-Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total	
IR-1: HCT and prevention services expanded and improved in target areas								
Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened								
P8.1D Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required		528,000	19,849	30,137	25,199	1,703	21,747	98,635
	Male	N/A	10,006	14,426	11,375	644	9,679	46,130
	Female	N/A	9,843	15,711	13,824	1,059	12,068	52,505
	10-14 years old	N/A	1,184	1,083	1,024	60	585	3,936
	15+ years old	N/A	18,665	29,054	24,175	1,643	21,162	94,699
P8.2D Number of the targeted population reached with individual and/or small group-level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required		158,400	3,885	8,355	5,688	0	7,600	25,528
	Male	N/A	2,022	3,954	2,889	0	3,508	12,373
	Female	N/A	1,863	4,401	2,799	0	4,092	13,155
	10-14 years old	N/A	812	914	542	0	416	2,684
	15+ years old	N/A	3,073	7,441	5,146	0	7,184	22,844
P8.3D Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards		75,000	3,767	5,076	7,826	1,265	3,290	21,224

By MARP type: CSW, IDU, MSM								
	CSW	N/A	1,431	1,601	3,707	453	799	7,991
	Truckers	N/A	1,957	1,969	2,914	564	1,122	8,526
	Fishermen	N/A	4	74	680	15	608	1,381
	Miners	N/A	0	751	0	221	491	1,463
	MSM	N/A	353	13	501	5	0	872
	Other vulnerable populations	N/A	22	668	24	7	270	991
	Male	N/A	2,354	3,298	4,504	799	2,377	13,332
	Female	N/A	1,413	1,778	3,322	466	913	7,892

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
RECO's communication kits were not completed.	Work with RECO to ensure the communication kits are completed for Q2.
Loss of interest and participation of members in CPCCs.	Put in place a mechanism to motivate CPCC members and activists.

Sub-IR 1.2: Community- and facility-based HIV counseling and testing services enhanced

Activities and achievements

Activity 1: Provide high-quality HIV counseling and testing (HCT) services to 220,000 priority beneficiaries. ProVIC successfully implemented and conducted both clinical and mobile/community-based HCT activities in all provinces during the reporting period. Additionally, ProVIC organized daytime HCT in all five provinces as a part of World AIDS Day activities; and in Kinshasa, worked with Association de Santé Familiale (ASF) and Population Services International (PSI) to hold a nighttime HCT. The HCT activity in Kisangani tested 112 CSWs, 8.9 percent of whom tested HIV positive.

To ensure the quality of project activities, ProVIC conducted training in biomedical waste management (in Katanga, with 30 participants); HCT (in Kisangani, with 23 service providers); and correct use of portable PIMA™ analyzers for CD4 count (in Bas-Congo, in collaboration with the PNLS, with six technicians).

Prevention of mother-to-child transmission of HIV (PMTCT), HCT, and provider-initiated counseling and testing (PICT) were supported with commodity supplies. ProVIC has begun discussions with the PNLS regarding revision of the normative documents related to PICT.

Activity 2: Provide and ensure integrated management of HIV/tuberculosis (TB) co-infection at all HCT sites (community, mobile, fixed).

Please see Activity 4 under Sub-IR 2.1 (page 17).

Overview of Q1 data

PEPFAR Indicator			Year 4 Annual Target	Year 4 Q1 Achievement					
				Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total
Sub-IR 1.2: Community- and facility-based HCT services enhanced									
P11.1D Number of individuals who received testing and counseling (T&C) services for HIV and received their test results			220,000	8,113	11,529	16,765	919	6,048	43,374
	By sex: Male and		N/A	3,367	4,749	7,748	104	2,257	18,225
		Female	N/A	4,746	6,780	9,017	815	3,791	25,149
	By age: <15 and		N/A	136	3,300	64	21	44	3,565
		15+	N/A	7,977	11,135	16,701	898	6,004	42,715
	By test result: Positive		N/A	399	862	591	51	152	2,055
	By test result: Negative		N/A	7,714	10,667	16,156	869	5,896	41,302
	Individual counseling/test		N/A	7,983	11,351	16,702	919	5,958	42,913
	Couple counseling/test		N/A	130	178	63	0	90	461
	CSW (for concentrated epidemics)		N/A	458	755	2,382	10	841	4,446
	IDU (for concentrated epidemics)		N/A	0	0	0	0	0	0
	MSM (for concentrated epidemics)		N/A	119	33	772	0	7	931
	TB		N/A	0	0	0	0	0	0

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Not enough vehicles to conduct all HCT activities as planned. Many delays have been out of the control of ProVIC, such as negotiations regarding exonerations between the United States and DRC governments.	Vehicle approval is in the hands of USAID. We request rapid action.
Little support from health institutions where commissions on biomedical waste have been established.	Conduct ongoing awareness-raising in each province and involve health authorities.
Lack of data collection on biomedical waste management.	Include MOH and health zone agents in joint formative supervisions. Include biomedical waste management in the template for the MOH supervision report.
Lack of resources for biomedical waste management facilities. Some large, public medical institutions generate waste (non-HIV related) that is beyond the capacity of ProVIC to manage.	Via Champion Community and government provincial health teams, mobilize resources to fund biomedical waste management in health districts.
Trained technical agents still needing close and regular formative supervision to master the use of the finger-prick technique for blood draws.	Intensify formative supervision and organize onsite refresher training for HCT and PICT providers.
DRC: Democratic Republic of Congo; MOH: Ministry of Health; USAID: United States Agency for International Development.	

Sub-IR 1.3: Prevention of mother-to-child transmission of HIV services improved

Activities and achievements

Activity 1: Improve access to comprehensive PMTCT services according to national norms in 41 ProVIC sites. In this quarter, ProVIC continued to be one of the main providers in the DRC of PMTCT services offered according to Ministry of Health (MOH) guidelines and in line with international recommendations from the World Health Organization (WHO). PICT for HIV was offered to all pregnant women who presented at ProVIC PMTCT sites. ProVIC sites continued to demonstrate high rates of test acceptance by pregnant women. Women testing positive for HIV received CD4 count testing, and depending on the result, were placed either on lifetime antiretroviral therapy (ART), or antiretroviral (ARV) prophylaxis for PMTCT. Care and treatment of HIV-positive women supported by ProVIC from testing through delivery was consistent with the nationally adopted WHO “Option A” protocol. All pregnant women who arrived at the labor and delivery ward without an HIV test result also received PICT for HIV.

In addition, ProVIC subsidized delivery fees for HIV-positive women at ProVIC sites during the reporting period. HIV-positive women were allowed to leave facilities after giving birth without paying delivery fees (normally in the DRC, a woman is retained at the site until her bills have been paid).

During routine supervisions in Q1, the PMTCT team continued to work with providers, health zone teams, and members of the community to encourage male partner participation in antenatal care (ANC) services. Written invitations in local languages continued to be given to pregnant women to invite their partners to accompany them to ANC appointments. In Year 3, PMTCT service providers hosted discussions with health zones and sites to see whether service hours could be extended to facilitate male partner attendance. In Q1 of Year 4, several sites began to offer longer service hours (on the weekends and during holidays) to make it easier for working partners to visit the sites. Male partners presenting at the sites were offered free HCT services according to national protocols. Also during ANC visits, pregnant women were encouraged by service providers to bring in other family members for testing. HIV-positive women in particular were requested to bring other members of the household for testing.

During this quarter, the PMTCT Specialist worked with sites to update mapping of Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) treatment services and to strengthen referrals to Global Fund sites.

Activity 2: Increase promotion and uptake of pediatric counseling and testing and improve follow-up of mothers and infants. ProVIC worked with Communication for Change (C-Change) to update national PMTCT educational tools used by providers (picture-based flipcharts used in ANC to educate women). The tools had not yet been revised to reflect the new national protocol for the feeding of HIV-exposed infants. This work is expected to continue into Q2. During this quarter, ProVIC continued to support sites in contacting mother-baby pairs lost to follow-up, through telephone calls and home visits.

Activity 3: Pilot and evaluate the Mentor Mother approach to improve the retention and adherence of mother-baby pairs in PMTCT services. The PMTCT Specialist worked on the finalization of tools for the Mentor Mother pilot, which is scheduled to take place at six PMTCT

sites in three provinces (Kinshasa, Katanga, and Province Orientale). Specifically, a day of experience-sharing (based on the Kenya model) with DRC MOH stakeholders was held in November 2012. The PNLS Deputy Director served as the primary facilitator of the meeting, and five members of the national team participated in the workshop. Importantly, there was collaboration with Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)/United States Centers for Disease Control and Prevention (CDC) team members to develop all of the critical materials for the pilot of the Mentor Mother approach in the DRC, including the:

- National guide for piloting the approach in the DRC. This guide is structured in sections, which cover the package of services, general working conditions, the monitoring and evaluation (M&E) framework, and roles and responsibilities of partners.
- Mentor Mother training guide (organized in 17 modules).
- Robust data collection tools to allow for analysis of results from the pilot.

These materials were developed over the course of a seven-day workshop led by the PNLS in collaboration with the National Department of Family Health, Programme National de Santé de la Reproduction (PNSR), and the EGPAF/DRC technical teams from United States Agency for International Development (USAID)- and CDC-supported projects. Among the data collection tools is a form for collecting baseline data, developed to allow comparison of results attained during the pilot.

The principal indicators (also called “primaries”) selected for the Mentor Mother pilot are listed in Table 1 below.

Table 1. Primary indicators for the Mentor Mother approach in the DRC.

Objective	Indicator
Empowerment of HIV-positive women.	Percentage of PMTCT clients who shared their HIV status with their sexual partners.
Retention of HIV-positive women during pregnancy.	Percentage of HIV-positive women who completed four ANC visits.
Retention of HIV-positive women after delivery.	Percentage of HIV-positive women who attended the postpartum visit six weeks after delivery.
Retention of HIV-exposed infants.	Percentage of HIV-exposed infants who received early infant diagnosis at six weeks of age.
Exclusive breastfeeding.	Percentage of HIV-exposed infants exclusively breastfed until six months of age.
Reduction of vertical transmission of HIV.	Percentage of HIV-exposed infants who tested negative at 18 months of age.

Activity 4: Increase the quality of PMTCT services.

Performance-Based Financing (PBF) pilot: In collaboration with the MOH PBF department, ProVIC finalized two prerequisites needed before signing of the PBF contract with the pilot site (Kikimi). These included the creation of a work plan of activities for the testing of the model at Kikimi, and the training of regulators, providers, and community members on the PBF concept.

PMTCT quality assurance/quality improvement (QA/QI) via Improvement Collaboratives: In close coordination with the national PNLS, ProVIC subcontractor University Research Co., LLC (URC) sent a consultant to the DRC to provide technical assistance in QA/QI for PMTCT using the Improvement Collaboratives approach. After conducting a baseline survey at PMTCT maternities supported by ProVIC, 17 participants, including national and provincial PNLS and health zone representatives and ProVIC staff, were trained as QA/QI coaches and charged with the success of the collaborative approach to introducing QA/QI teams in targeted maternities. Rollout of the Improvement Collaboratives approach began immediately in four Kinshasa maternities and will intensify in the coming quarters.

Other quality improvement activities: Improvements were noted in the quality of dried blood spot draws for early infant diagnosis. In Year 3, many samples were rejected by the national laboratory for poor quality. Following refresher training and assistance in the collection of high-quality samples during supervisions, no samples were rejected by the national laboratory.

ProVIC successfully introduced new data collection tools with harmonized indicators approved by the MOH which integrate PMTCT and maternal and child health and nutrition activities and provide key questions to pose to pregnant women to screen for GBV and TB. The tools also provide information on family planning to offer to clients during provision of ANC and postpartum services, with emphasis on the importance of prevention of both pregnancy and sexually transmitted infections (STIs) for HIV-positive women who do not wish to have children.

Activity 5: Increase linkages with maternal and child health services and other program areas.

The PMTCT team was very involved in looking at and improving continuum of care for pregnant women, from ANC to delivery, and from delivery to follow-up of the infant through 18 months of age. Working sessions were hosted with providers to discuss these issues and suggest improvements to client flow to reduce the number of visits required of pregnant women and mother-infant pairs. Following the introduction of QA/QI teams in the maternities, clear descriptions of provider responsibilities were introduced in ANC, labor and delivery, and young child services at selected sites. Formal meetings were also established for site staff to discuss service provision and areas for improvement.

The PMTCT Specialist worked with providers, the PNLS, and the PNSR on the effective launch of syphilis testing at selected “PMTCT+” sites. Although the introduction of syphilis testing had been planned for Year 3, challenges related to the conservation of the cold chain for testing materials delayed the launch of this component. Sites in Katanga, Bas-Congo, and Sud Kivu started testing pregnant women for syphilis in the reporting period, and providing treatment for positive women and their male partners. To date, 25 sites are providing syphilis testing; we expect to bring this number to 44 by the end of Q2.

An important aspect of increasing linkages was to stress collaboration between PMTCT sites and Champion Community SHGs. Referral and counter-referral slips were analyzed by teams from the PMTCT sites and communities in order to improve the integrated management of HIV-positive women within family and community structures. Providers were advised to encourage HIV-positive women to attend and adhere to SHGs in order to benefit from psychosocial services and positive prevention offered within the groups.

Activity 6: Reinforce government capacity to offer high-quality PMTCT services. During Q1, the PMTCT team continued to collaborate with the MOH during monthly meetings with the PNLS on the state of PMTCT activities at different sites in the DRC. The PBF pilot in Kikimi, the team-based approach to QA/QI at four maternities in Kinshasa, and the pilot of the Mentor Mother approach at six sites all benefited from the technical support and exchange with the PNLS during the processes of planning, generating interest in, and involving key stakeholders. The PMTCT team played an active role in the work organized by the Department of Family Health to revise the national norms on the health of mothers, newborns, and children, as well as the realization of integrated tools such as the child health book, ensuring that important aspects of the PMTCT process, such as early infant diagnosis, are represented in these documents and tools.

The PMTCT team, in collaboration with provincial PNLS in Kinshasa, Bas-Congo, Katanga, and Sud Kivu, organized a refresher training for providers in the integrated HIV module focused on PMTCT at the 16 existing “pre-acceleration” PMTCT sites. Participants included ProVIC health zone chief medical officers, medical directors from the sites, nurses, and laboratory technicians. The ProVIC team also updated checklists and memory aids for providers, which are affixed to the walls in service delivery areas to support the quality of service provision.

Overview of Q1 data

Table 3. PMTCT cascade indicators, by province, Q1 Year 4.

Key indicators	Kinshasa	Province Orientale	Katanga	Bas-Congo	Sud Kivu	Total
# Women received at ANC	3,836	689	1,977	1,006	1,433	8,941
# Women counseled on HIV	4,368	762	3,930	1,479	2,136	12,666
# women who received HCT and received their test results	4,329	762	3,300	1,440	2,049	11,880
# women identified HIV+	46	22	103	29	23	223
# of known HIV+ women	7	5	0	6	7	25
# total HIV+ pregnant women	53	27	103	35	30	248
# women who received CD4 count testing	53	25	88	22	14	202
# women placed on ARV for PMTCT	50	20	88	18	23	199
# women who received AZT	20	15	57	13	14	119
# women on ART	30	5	31	5	9	80
# women who received syphilis testing	0	0	1,136	209	543	1,888
# HIV+ women referred for psychosocial support	0	4	0	8	21	33
# women who delivered at ProVIC-supported facility	33	9	24	10	6	82
# infants placed on NVP	34	9	24	13	6	86
# infants tested for HIV within 12 months (EID)	26	11	13	10	3	63
# infants placed on CTX	24	11	13	5	1	54
# male partners who received HIV counseling	328	134	66	50	79	657
# male partners who received HIV testing	328	134	35	50	79	626
# male partners who tested HIV+	7	3	10	1	2	23

# male partners who received CD4 count testing	6	3	0	1	1	11
# male partners placed on ART	0	0	0	1	1	2
# male partners who received CTX	6	3	7	1	2	19
# other family members counseled on HIV	0	0	0	0	0	0

Based on this data, we can see the following trends:

- These results are encouraging, in that 43 ProVIC-supported health facilities, including 25 new acceleration sites, are now offering PMTCT services. Implementation challenges to launching new sites must be taken into account when comparing these results against targets. Among the difficulties encountered were poor provider skills in using rapid HIV tests and in drawing samples for CD4 counts and EID, as well as providers' discomfort disclosing positive results to clients. ProVIC continues to work with site and health zone staff to overcome these challenges.
- Of the total 12,666 women counseled, 11,880 women, or 94 percent, were tested for HIV and received their results. 248 women were HIV positive (223 tested at these sites, and 25 who arrived at the sites with a known positive status). The 11,880 pregnant women counseled, tested, and receiving their results represents a good start to the project year given the aforementioned challenges. These findings give a general HIV prevalence of 2 percent among pregnant women who agree to be tested at our sites. This overall seropositivity masks certain trends, such as the General Reference Hospital in Boma in Bas Congo and Sendwe hospital in Katanga have respective rates of HIV of 5.6 percent and 4.5 percent at CS Camille in Kisangani, amongst pregnant women. ProVIC is focusing special attention on these sites to ensure service quality, retention, and follow-up for women as well as exposed infants.
- Over the course of this quarter, the PMTCT program counseled 8,941 women at ANC's and 3,725 women at labor and delivery (for a total of 12,666 women). Thus 29 percent of ProVIC's PMTCT clients presented for labor and delivery. This weak return rate is a problem nationally, and not just at ProVIC sites. ProVIC continues efforts to improve retention and hopes that piloting the Mentor Mother approach will help address this challenge at pilot sites.
- Of the total 248 HIV-positive women reached with PMTCT services during Q1, 202 were clinically evaluated using CD4 testing and 199 were placed on ART or ARV or prophylaxis for PMTCT. The slightly low proportion of HIV-positive pregnant women placed on ARV (76 percent overall) compared to a target of 96 percent is due to some providers not accounting for and documenting women who arrive at the site with a known HIV-positive status, even in the case of women already on ARVs for PMTCT.
- During the quarter, 82 HIV-positive pregnant women delivered at ProVIC PMTCT sites (including four sets of twins), and 86 infants born to HIV-positive mothers received ARV prophylaxis. Early infant diagnosis of 63 HIV-exposed infants was conducted during Q1, and 54 infants were initiated on cotrimoxazole prophylaxis. One infant received a rapid HIV test at 18 months of age and was found negative. Children born to HIV-positive women who deliver at a ProVIC-supported health facility are currently receiving appropriate care, but ProVIC's low rate of and underreporting related to early infant diagnosis are linked to the same problems noted above.

- At the ANC, 1,888 pregnant women from Katanga, Bas Congo, and South Kivu were tested for syphilis, and 18 positive women were identified and treated along with their male partners according to the PNLIS methodology.
- In support of ProVIC's efforts at engaging male partners of pregnant women in PMTCT, 657 male partners were counseled for HIV, and 626 were tested and received their results. Twenty-three men tested HIV positive, indicating a seropositivity rate of 3.7 percent among male partners of ANC clients opting to visit the ANC. Nineteen men were placed on cotrimoxazole, and two of the men who received CD4 count testing were eligible for and placed on ART.
- The collaboration with the self-help groups, weak at the beginning of the program, encouraged 33 women (8 in Bas Congo, 4 in Province Orientale and 21 in South Kivu) to participate in self-help meetings. This result cannot be compared to earlier performance, as data on these indicators has just begun to be collected. ProVIC looks forward to providing a more robust analysis with future reports.
- A strong effort continues to:
 - Involve male partners, which is very weak, especially in Katanga where there are 10 new PMTCT sites;
 - Increase TB screening;
 - Increase client acceptance of double protection (with only 47 women, 5 in Bas Congo and 41 in South Kivu, accepting during Q1); and
 - Follow-up of HIV-exposed infants until 18 months.

Summary of PMTCT data, by province.

PEPFAR Indicator	Year 4 Annual Target	Year 4 Q1 Achievement					
		Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total
Sub-IR 1.3: PMTCT services improved							
P1.1D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	50,000	1,440	3,300	4,329	762	2,049	11,880
Known positives at entry	6	0	7	5	7	25	34
Number of new positives identified	29	103	46	22	23	223	229
P1.2D Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission	96%	51%	85%	94%	74%	77%	76%
<u>Numerator</u> : Number of known HIV-positive pregnant women who received ARVs to reduce risk of MTCT (reported)	N/A	18	88	50	20	23	199
Single-dose Nevirapine only	N/A	0	0	0	0	0	0
Maternal AZT	N/A	13	57	20	15	14	119
Prophylactic regimens using a combination of 3 ARVs	N/A	0	0	0	0	0	0

	ART for HIV-positive women eligible for treatment	N/A	5	31	30	5	9	80
	<u>Denominator:</u> Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	N/A	35	103	53	27	30	248
	C4.1D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	40%	29%	13%	49%	41%	10%	25%
	<u>Numerator:</u> Number of infants who received an HIV test within 12 months of birth during the reporting period	N/A	10	13	26	11	3	63
	Infants who received virological testing in the first 2 months	N/A	3	13	14	1	2	33
	Infants who were tested virologically for the first time between 2 and 12 months or who had antibody test between 9 and 12 months	N/A	7	10	4	1	1	23
	<u>Denominator:</u> Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)	N/A	35	103	53	27	30	248
	C4.2D Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	20%	14%	13%	45%	41%	3%	12.4%
	<u>Numerator:</u> Number of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	N/A	5	13	24	11	1	54
	<u>Denominator:</u> Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)	N/A	35	103	53	27	30	248
	T1.1D. Number of adults and children with advanced HIV infection newly enrolled on ART	407	0	31	8	5	0	44
	By Age/Sex: <15 Female	N/A	0	0	0	0	0	0
	By Age/Sex: <15 Male	N/A	0	0	0	0	0	0
	By Age/Sex: 15+ Female	N/A	31	8	5	0	44	44
	By Age/Sex: 15+ Male	N/A	0	0	0	0	0	0
	By Age: <1	N/A	0	0	0	0	0	0
	By: Pregnant Women	N/A	31	8	5	0	44	44

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Although progress is being noted, ongoing integration of PMTCT activities at the community level remains a challenge.	Conduct working sessions with health zone teams, providers, and community agents on the referral and counter-referral processes for HIV-positive women to and from SHGs.
Low rate of return of HIV-positive women to deliver at the PMTCT site where they attended ANC.	Integrate PMTCT messages and messages about safe motherhood into community messaging activities. Strengthen educational materials for PMTCT in collaboration with C-Change. Pilot the Mentor Mother approach.
Follow-up of exposed infants.	Support providers in the use of the exposed infant follow-up card. Pilot the Mentor Mother approach.
Low participation of male partners.	Extend site service hours to weekends and holidays to facilitate male attendance. Pilot the Mentor Mother approach, which engages male partners in support and educational meetings.

Sub-IR 1.4: Community- and facility-based gender-based violence prevention and response services strengthened

Activities and achievements

Activity 1: Develop the “Champion Men/Champion Women” approach in communities to strengthen the participation of men in activities against sexual and gender-based violence (SGBV). In December 2012, 80 peer educators and community relays (38 women and 42 men) from four champion communities in Kisangani (Kabondo, Malkia, Neema, and Pumuzika) benefited from a seven-day integrated capacity-building training, including topics such as HIV, GBV, and family planning. The training was led by the ProVIC GBV Specialist, in collaboration with the PNLS, PNSR, and DIVGFE). The training curriculum and materials were adopted by the DRC government, and DIVGFE and other government partners (PNLS, Central Health Zone Bureaus, and PSNR actively participated in the sessions.

A workshop was held on October 23, 2012 at the ProVIC office in Kinshasa, with technical support from PATH’s Washington, DC-based Program Associate for Gender and GBV. This meeting served as an opportunity for the entire ProVIC technical team to participate in constructive discussions on the Champion Men/Champion Women approach developed by PATH and to contribute to the strategy’s enrichment. Following the workshop, field visits were conducted in order to share the strategy with targeted communities in Kinshasa and to collect community members’ feedback on the approach. During these field visits, the ProVIC team also requested feedback from community members on the criteria to be used to determine Champion Men and Champion Women, as well as how best to implement and monitor the approach. Four champion communities were visited, including Kikimi, Masina II, Kinkenda, and Mankana. Suggestions and feedback from the discussions were incorporated into a draft strategy document, which was shared with key government partners during one-on-one meetings, including the Ministry of Gender, Family & Children and the PNSR, as well as other partners, including Projet Intégré de Sante, in

order to strengthen collaboration among USAID projects. A similar approach will take place in Kisangani.

International End Violence Against Women Day was commemorated on November 25, 2012, and activities were supported and carried out during the 16 Days of Activism Against Gender Violence, including outreach activities in two champion communities in Kisangani, advocacy for policymakers in the community of Tshopo, and an awareness-raising session at a school in Malkia.

Activity 2: Support health care providers to screen for SGBV effectively in the PMTCT setting.

Two training sessions for health care providers on the management of SGBV were organized during the reporting period, in Kinshasa and Kisangani. All trained providers will be able to perform SGBV screening to support victims according to national standards and to provide referrals to other support structures in order to provide holistic care to survivors.

Given that the country does not yet have a standardized SGBV screening tool, ProVIC is using a tool developed by the University of North Carolina in collaboration with the PNLS. The tool incorporates screening questions for physical, psychological, and sexual abuse. Questions are preceded by an introduction, and provide guidance on sensitivity, compassionate care, and how to communicate with survivors. The screening tool was made available to all sites, allowing trained providers to screen all patients for experiences of SGBV. Monitoring the use of the screening tool was conducted through a follow-up visit after the training in Kisangani (Mokili, Neema, and Malkia). The tool and GBV indicators and targets were reviewed.

Activity 3: Provide high-quality medical and psychosocial support services to SGBV survivors.

At the end of the provider training, ProVIC provided post-exposure prophylaxis (PEP) kits in eight sites (five in Kinshasa and three in Kisangani). The kits (39 adult and pediatric kits) were provided by the United Nations Population Fund to allow health structures to meet the needs of survivors of sexual violence. Data collection tools and data management for SGBV were also made available (e.g., medical records for survivors, sexual assault register, medical certificate, and records for medical reporting).

Activity 4: Strengthen the capacity of national and intervention partners and key stakeholders to lead efforts to address GBV, and improve information management/sharing on SGBV.

On November 28, 2012, ProVIC participated in a coordination meeting for SGBV stakeholders in Eastern Province, held at C-Change. The meeting had two main objectives: reinvigorating the operating framework for coordination of SGBV interventions; and planning activities for International End Violence Against Women Day and the 16 Days of Activism Against Gender Violence. As part of the partnership with other United States government actors, contacts were made with C-Change for the development of key messages on GBV and the GBV/HIV link. A workshop is planned for Q2 to develop messages and materials.

Overview and discussion of monitoring and evaluation data

Table 3. Preliminary data compiled for five PMTCT sites (Kinhsasa and Kisangani): Kikimi, Libondi, Malkia, Neema, and St. Camille.*

GBV indicator	Target
Number of pregnant women screened for GBV through PMTCT sites	120
Number of men screened for GBV (including the partners of pregnant women attending PMTCT sites)	10
Number of non-pregnant women screened for GBV	13
Number of male survivors of GBV identified	1
Number of female survivors of GBV identified	12
Number of GBV survivors who received services	13
Number of GBV survivors provided with post-rape PEP kits	0
Number of GBV survivors referred to additional services	1
Number of health personnel exposed to HIV who received HIV PEP	2

* Please note that non-PEPGAR NGI GBV data is still being processed in ProVIC's M&E database.

Overview of Q1 data

PEPFAR Indicator		Year 4 Annual Target	Year 4 Q1 Achievement					
			Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total
Sub-IR 1.4: Community and facility-based GBV prevention and response services strengthens								
P6.1D Number of persons provided with post-exposure prophylaxis (PEP)		336	N/A	N/A	2	0	N/A	0
	By Exposure Type: Occupational	N/A	N/A	N/A	2	0	N/A	0
	By Exposure Type: Other non-occupational	N/A	N/A	N/A	0	0	N/A	0
	By Exposure Type: Rape/sexual assault victims	N/A	N/A	N/A	0	0	N/A	0
P12.5.D Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV pilot indicator)		126,000	N/A	N/A	2,966	199	N/A	3,165
	By age: 0-4	N/A	N/A	N/A	0	0	N/A	0
	5-9	N/A	N/A	N/A	0	0	N/A	0
	10-14	N/A	N/A	N/A	320	0	N/A	320
	15-17	N/A	N/A	N/A	0	0	N/A	0
	18-24	N/A	N/A	N/A	1,078	72	N/A	1,150
	25+	N/A	N/A	N/A	1,568	127	N/A	1,695
	By sex: Male and	N/A	N/A	N/A	1,272	107	N/A	1,379
	Female	N/A	N/A	N/A	1,694	92	N/A	1,786
P12.6.D Number of GBV service-encounters at a health facility (GBV pilot indicator)		10,400	N/A	N/A	236	10	N/A	246
	By age: 0-4	N/A	N/A	N/A	3	0	N/A	3
	5-9	N/A	N/A	N/A	0	0	N/A	0
	10-14	N/A	N/A	N/A	0	0	N/A	0

	15-17	N/A	N/A	N/A	4	2	N/A	4
	18-24	N/A	N/A	N/A	145	5	N/A	150
	25+	N/A	N/A	N/A	84	3	N/A	87
	By sex: Male and	N/A	N/A	N/A	10	0	N/A	10
	Female	N/A	N/A	N/A	226	10	N/A	236
	By type of service: GBV screening	N/A	N/A	N/A	226	10	N/A	236
	Post GBV-care	N/A	N/A	N/A	9	10	N/A	19
P12.7. Number of health facilities reporting that they offer (1) GBV screening and/or (2) assessment and provision or referral to the relevant service components for the management of GBV-related health needs		13	N/A	N/A	5	1	N/A	6
	By type of facility: Clinical	N/A	N/A	N/A	5	1	N/A	6
	Community	N/A	N/A	N/A	0	0	N/A	0
	By type of service: GBV screening	N/A	N/A	N/A	5	1	N/A	6
	Post GBV-care	N/A	N/A	N/A	2	1	N/A	3

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Weakness in the health structure data collection system: problems with completeness and timeliness in reporting.	Make available the GBV level to health structures to facilitate data collection.
Absence of a specific approach to address issues related to mental health for GBV survivors.	Harmonize with Programme National de Santé Mentale (National Mental Health Program) and the PNSR on training content.

Activities planned for the next quarter for Intermediate Result 1

Sub-IR 1.1 <i>Communities' ability to develop and implement prevention strategies strengthened</i>	Sub-IR 1.2 <i>Community- and facility-based HCT services enhanced</i>	Sub-IR 1.3 <i>PMTCT services improved</i>	Sub-IR 1.4 <i>Community- and facility-based GBV prevention and response services strengthened</i>
Organize sensitization with key HIV prevention messages for MARPs, the general population, and youth.	Train providers in Kisangani on use of the finger-prick technique for blood draws.	Integrate testing for syphilis, TB screening, and family planning services at PMTCT sites in Kinshasa and Kisangani.	Support activities to promote gender equality through Champion Men/Champion Women.
Reproduce and disseminate different communications tools targeting MARPs and the general population.	Train technical agents and retrain providers in biomedical waste management.	Improve follow-up of mother-infant pairs during the 18-month period.	Train providers on high-quality care and support for SGBV survivors (APS).
Train providers at youth-friendly centers on HIV prevention and management of STIs.	Supply HCT/PICT and PMTCT facilities with necessary commodities.	Pilot the Mentor Mother approach at six sites in three provinces.	Provide high-quality medical and psychosocial support services to SGBV survivors.
Organize community meetings among champion	Support the PNLS to revise PICT training	Support newly introduced QA/QI collaboration in	Monitor use of the SGBV screening tool during

Sub-IR 1.1 <i>Communities' ability to develop and implement prevention strategies strengthened</i>	Sub-IR 1.2 <i>Community- and facility-based HCT services enhanced</i>	Sub-IR 1.3 <i>PMTCT services improved</i>	Sub-IR 1.4 <i>Community- and facility-based GBV prevention and response services strengthened</i>
communities to exchange best practices.	documents.	four Kinshasa maternities.	ongoing project monitoring activities at health facilities.
Transform existing CPCCs into local community-based associations with legal status.	Ensure co-supervision for HCT and PICT activities and biomedical waste management.	Launch PBF in Kikimi in Kinshasa.	

Intermediate Result 2: Care, support, and treatment for people living with HIV/AIDS and orphans and vulnerable children improved in target areas

Sub-IR 2.1: Care and support for people living with HIV/AIDS strengthened

Activities and achievements

Activity 1: Strengthen early identification of HIV-infected persons, and linkages to and retention in care. A framework for collaboration with government and other partners has been finalized. Monthly meetings will be held to work on the linkages between health facilities and the community, systematic use of referral and counter-referral tools, integration of SHGs into health facilities, facility-led supervision of community services and reporting, etc. This framework will facilitate better coordination between all the key partners in the referral system, strengthening it and making it more effective and efficient and therefore better able to meet the needs of PLWHA and OVC.

Activity 2: Reduce morbidity and mortality of PLWHA through facility- and community-based interventions. The United States President's Emergency Plan for AIDS Relief (PEPFAR) guidance regarding cotrimoxazole provision has been extensively shared among ProVIC partners, including the plans for cotrimoxazole distribution via health facilities rather than SHGs. After the poor performance in 2012 with regard to TB screening, a number of meetings took place in Q1 with key stakeholders, including PATH's TB2015 project, La Ligue National pour la lutte contre la Tuberculose (the National League to Fight Tuberculosis), le Club des Amis Damien, and TB specialists from PATH headquarters and USAID to boost this indicator and bring us in line with PEPFAR guidelines, which state that 100 percent of PLWHA should benefit from TB screening. A TB screening acceleration plan also was developed in Q1 for the sites supported by ProVIC to address this issue within the community and within the health facilities. Additionally, guidelines on TB screening were shared with all provincial offices and grantees, and the screening form was circulated.

In Q1, 43 caregivers were trained (21 in Katanga and 22 in Kisangani) in the identification of malnutrition and palliative care. Under the supervision of health zone nutritionists, caregivers will periodically assess the nutritional status (using mid-upper arm circumference for adults and children) of all PLWHA and provide advice on maintaining good nutrition during SHG meetings and home-based care visits, as well as at medical and ANC appointments in health facilities (using anthropometric measures and other medical examinations).

This training has also ensured that caregivers have a better understanding of the referral process and tools, enabling better documentation and facilitation of case monitoring. Additionally, they are now better equipped to make home visits and to provide families with nutritional advice and counseling.

Activity 3: Improve the quality of life of PLWHA. After receiving training on the Voluntary Savings and Loan Association (VSLA) approach in September 2012, ProVIC nongovernmental organization (NGO) partners in Kinshasa and Bas-Congo developed implementation plans for this approach in champion communities with the support of a consultant from CARE International designated by Livelihoods and Food Security Technical Assistance (LIFT). In pilot sites in Bas-Congo and Kinshasa, the VSLA activity will replace traditional income-generating activities as the primary strategy for household economic strengthening.

A health review questionnaire for PLWHA has been developed and a care pathway for PLWHA drafted. These tools will be finalized and put into use by those delivering care during home visits. The tools will be useful in analyzing how the referral system is functioning as well. In addition, the palliative care guide has been circulated at trainings. This guide enables caregivers to evaluate pain and other symptoms and understand when they should refer cases.

Discussions are ongoing with ASF/PSI to provide water purifiers for distribution to members of SHGs and during home visits, in many cases acting as sources of revenue for champion communities such as Kasumbalesa, which has significant clean water issues. Advice on safe drinking water and hand hygiene is given to PLWHA during SHG meetings to decrease the incidence of disease related to dirty water and poor hand hygiene. After discussions with USAID throughout this quarter, the need for insecticide treated nets (ITNs) is being quantified and will be communicated to USAID for approval. Collaboration with the national malaria control program is planned for Q2 to address this need.

Activity 4: Provide and ensure integrated management of HIV/TB co-infection at all HCT sites (community, mobile, fixed). Maps of TB diagnosis and treatment sites in the health zones have been drawn up and will be maintained. The sharing of the TB screening form and guidelines and development of the TB screening acceleration plan detailed under Sub-IR 2.1 Activity 2 (above) illustrate the importance placed on improving this aspect of ProVIC's work.

Activity 5: Strengthen the capacity of all those involved to deliver high-quality adult care and support. In addition to provision of training, regular supportive supervision visits have continued to be provided to ensure standards of provision and quality of service delivery for PLWHA. The establishment of sharing networks for those involved in home-based care, SHGs, and child-to-child (C2C) groups has been delayed due to competing priorities and will start up in Q2 in Katanga and Bas-Congo. Documenting and sharing of lessons learned and best practices have started and will be an ongoing sub-activity.

Overview of Q1 data

PEPFAR Indicator	Year 4 Annual Target	Year 4 Q1 Achievement						
		Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total	
Sub-IR 2.1: Palliative care strengthened								
C1.1D Number of eligible adults and children provided with a minimum of one care service		21,691	884	2,668	4,186	307	1,406	9451
	By Age: <18,	N/A	261	1,672	1,831	91	661	4516
	By Age: 18 +	N/A	623	996	2,355	216	745	4935
	By sex: Male	N/A	366	1,099	1,445	86	524	3520
	By sex: Female	N/A	518	1,569	2,741	221	882	5931
C2.1D Number of HIV-positive adults and children receiving a minimum of one clinical service		9,686	590	764	2,035	105	420	3914
	By age: <15	N/A	26	280	757	1	40	1104
	By age: 15 +	N/A	564	484	1,278	104	380	2810
	By sex: Male	N/A	218	173	587	13	102	1093
	Female	N/A	372	591	1,448	92	318	2821
C2.2D Percentage of HIV-positive persons receiving cotrimoxazole prophylaxis		100%	98%	58%	75%	14%	35%	69%
	Numerator: Number of HIV-positive persons receiving cotrimoxazole prophylaxis	9,686	579	441	1,517	15	146	2,698
	Denominator: Number of HIV-positive individuals receiving a minimum of one clinical service	9,686	590	764	2,035	105	420	3,914
	By sex: Male	N/A	211	105	479	0	34	829
	Female	N/A	368	336	1,038	15	112	1869
	By age: <15	N/A	26	34	703	0	2	765
	By age: 15+	N/A	553	407	814	15	144	1933
C2.4D. Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings		100%	3%	21%	57%	47%	40%	40%
	Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment settings	9,686	19	161	1158	49	169	1556
	Denominator: Number of HIV-positive individuals receiving a minimum of one clinical service	9,686	590	764	2035	105	420	3914
	By sex: Male	N/A	6	37	329	4	36	412
	Female	N/A	13	124	829	45	133	1144
	By age: <15	N/A	7	89	310	0	3	409
	By age: 15+	N/A	12	72	848	49	166	1147
P7.1D Number of people living with HIV/AIDS (PLWHA) reached with a minimum package of prevention with PLWHA interventions		2,600	426	226	196	79	145	1072

Number reached in clinic/facility setting	N/A	8	1	2	0	3	14
Number reached in community/home-based setting	N/A	418	225	194	79	142	1058

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Linkages and integration of the SHGs into the health facilities need to be more effective.	Develop objectives for each care and support manager and the grantees include integrating SHGs into all health facilities with which ProVIC has an agreement.
The referral and counter-referral systems require strengthening to realize their full potential in providing a continuum of care and linkage between facilities.	Finalize Accords of Collaboration with health zones, which will improve health zone leadership and participation. Recruit health systems strengthening officers to support the high volume of work with referral and integration issues at the health zone, community, and facility levels.
ProVIC's responsibility is to screen PLWHA for TB infection and refer for testing and treatment as necessary. However, there problems with the availability of equipment, reagents, and treatment at some referral centers, which need to be acknowledged and addressed if ProVIC is to play an effective role in combating HIV/TB co-infection. The capacity of detection and treatment health centers to manage multidrug-resistant TB and awareness within communities of the stigma associated with TB are also challenges.	ProVIC will continue to share information on stockouts with the TB2015 project, which will in turn communicate with the national TB program and USAID. Refer suspected cases to detection and treatment health centers, which are known to have the necessary equipment and reagents, and consider subsidization of transport costs by grantees.
Initiation of the VSLA approach has been slow in getting off the ground.	Sign a memorandum of understanding with LIFT for effective technical assistance, designating a LIFT focal point within ProVIC. Train VSLA agents via CARE International in Q2 and commence activity.
Lack of water purification tablets and ITNs to prevent diarrhea and malaria.	Sign collaboration agreements with ASF/PSI and the national malaria control program to make all the necessary inputs available.

Sub-IR 2.2: Care and support for orphans and vulnerable children strengthened

Activities and achievements

Activity 1: Support families to assess the needs of their children and to access the necessary services and support to decrease their vulnerabilities. Information was gathered in Q1 on operational *mutuelles de santé* (Mutualité des Sages Femmes de Kinshasa, MUSECKIN), which shows that the average monthly subscription is \$2.30 per person, with a registration fee of \$5. This exceeds the \$5 per person/year that ProVIC allocates for health care. As an alternative, ProVIC has signed agreements with medical facilities or utilized a mobile medical team to meet the health needs of OVC. In Q2, a meeting will be held between *mutuelles* and grantees to facilitate working partnerships and with a view to getting OVC signed up to the *mutuelles*.

Activity 2: Strengthen OVC education and address barriers to education. During the reporting period, ProVIC's HIV and OVC Specialist held meetings with the Ministry of Primary, Secondary and Vocational Education (represented by three provincial division heads), Ministère des Affaires Sociales (MINAS), and the Catholic Schools Coordinating Body (écoles conventionnées catholiques) (represented by the managers of six sub-divisions). These meetings led to the following decisions:

- The Ministry of Primary, Secondary and Vocational Education is willing to facilitate the integration of OVC identified by ProVIC grantees into public schools, based on the government directive that 10 percent of the student body of public schools be comprised of vulnerable children attending free of charge.
- The Catholic Schools Coordinating Body is supportive of ProVIC and its partners ensuring education for more OVC through a partnership agreement between itself and ProVIC.

These opportunities can only be taken up at the start of the next school year (2013-2014). For this to happen, ProVIC must obtain official approval from USAID to sign a partnership with the Catholic Schools Coordinating Body and to begin activities. A list of OVC with full addresses needs to be provided to the Catholic Schools Coordinating Body and the Ministry of Primary, Secondary and Vocational Education.

Additionally, ProVIC prepared programming guidelines that will govern the implementation of OVC activities. These summary guidelines were based on the new PEPFAR OVC guidance and lay out priorities in relation to OVC education, including prioritization of access to primary education and completion of primary studies, reduction in educational disparities between girls and boys, strengthening of the relationship between communities and the schools, and the importance of taking into account the job market in terms of career advice for OVC. Technical orientation meetings were organized with grantees in all provinces to share these guidelines and to ensure that each organization adopts them.

Activity 3: Increase the awareness of families and other persons involved with children around how to reinforce child protection and children's rights. Partnerships in Year 3 with the Centre de Solidarité Nationale (National Center for Solidarity) in Kinshasa and Héritiers de la Justice (Inheritors of Justice) in Sud Kivu continue in Year 4. ProVIC plans to partner with SOS Enfante et Personne Vulnérable (SOS Child and Vulnerable Person) in Kisangani to continue its legal and/or judicial support for PLWHA and OVC (to be finalized in Q2). The child protection policy document has been finalized and disseminated.

Activity 4: Strengthen OVC capacity to deal with reproductive health and environmental issues. The new version of the child-to-child manual has been printed, providing guidance to C2C group facilitators on programming and facilitation of C2C meetings. A training workshop took place in Kinshasa on the use of the updated manual, during which 63 facilitators and social workers were trained. This new manual incorporates aspects of education around family life, reproductive health, hygiene, and environmental sanitation. This training will help improve the quality of services available via social workers and C2C groups to OVC and their families.

Overview of Q1 data

PEPFAR Indicator		Year 4 Annual Target	Year 4 Q1 Achievement					
			Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total
Sub-IR 2.2: Care and support for OVC strengthened								
C5.1D Number of eligible clients who received food and/or other nutrition services		2,902	666	733	1065	3	750	3217
	By sex: Male	N/A	278	327	389	0	282	1276
	Female	N/A	388	406	676	3	468	1941
	By Age: <18,	N/A	238	526	588	0	359	1711
	18+	N/A	428	207	477	3	391	1506
	Pregnant	N/A	0	0	0	0	0	0
	Lactating women	N/A	0	0	0	0	0	0
C5.3.D. Number of eligible children provided with health care referral		1,450	53	143	107	0	13	316
C5.4.D. Number of eligible children provided with educational and/or vocational training		1,300	60	395	474	89	208	1226
C5.5.D. Number of eligible adults and children provided with protection and legal aid services		230	1	1	13	0	1	16
By Age: <18		N/A	1	0	6	0	0	7
By Age: 18+		N/A	0	1	7	0	1	9
C5.6.D. Number of eligible adults and children provided with psychological, social or spiritual support		20,680	466	1801	3368	201	1267	7103
By Age: <18		N/A	126	999	1453	0	581	3159
By Age: 18+		N/A	340	802	1915	201	686	3944
C5.7.D. Number of eligible adults and children provided with economic strengthening services		560	0	39	157	0	1	197
	By Age: <18	N/A	0	0	20	0	0	20
	By Age: 18+	N/A	0	39	137	0	1	177

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Enrollment by grantees of OVC and PLWHA in <i>mutuelles de santé</i> .	Organize a three-way meeting between ProVIC, grantees, and <i>mutuelles</i> to facilitate the enrollment of OVC and PLWHA in <i>mutuelles de santé</i> (HIV and OVC Specialist and CBCT Specialist).
The need to obtain USAID approval to sign a partnership agreement that will enable ProVIC to take up existing opportunities using the 10 percent rule and with the Catholic schools.	Present and discuss with USAID the opportunities identified and obtain approval.
Effective incorporation of themes (education around family life, reproductive health, hygiene, and	Monitor meeting agendas and oversee the incorporation of themes.

Challenge	Proposed solution
environmental sanitation) into C2C meetings and home-based care.	
Inconsistent facilitation of C2C groups.	Ensure proficiency in the C2C approach through training, post-training monitoring, and mentoring.

Activities planned for the next quarter for Intermediate Result 2

Sub-IR 2.1 <i>Care and support for PLWHA strengthened</i>	Sub-IR 2.2 <i>Care and support for OVC strengthened</i>
Organize a workshop with the PNLS and other partners to validate the palliative care guide.	Organize a three-way meeting between ProVIC, grantees, and <i>mutuelles de santé</i> to facilitate the enrollment of OVC and PLWHA in <i>mutuelles</i> to give them access to health care.
Finalize TB plans with the TB2015 project.	Plan and organize seven meetings between parents and children within champion communities on subjects/problems linked to the well-being of OVC (three in Kinshasa, two in Bas-Congo, and two in Lubumbashi).
Continue integration of the TB screening checklist into mobile, fixed, and integrated voluntary counseling and testing services.	Discuss with USAID opportunities arising from meetings with educational partners, including the Catholic church educational system.
Address the availability of water purification tablets and ITNs via meetings with PSI and the national malaria control program.	Organize two briefing sessions for facilitators of C2C groups (Kisangani and Lubumbashi), and disseminate the child-to-child manual in all provinces.
Organize NACS training for care providers in Kinshasa.	Organize four training/awareness-raising meetings for teachers on the concept of schools as centers of care and support for OVC (two in Kinshasa and two in Bas-Congo).
Document successful aspects of the care and support component in each province to promote learning between ProVIC's program areas.	
Organize a workshop with C-Change to develop key messages for PLWHA.	
Roll out the VSLA approach in a number of pilot sites.	
NACS: nutrition assessment, counseling and support.	

Intermediate Result 3: Strengthening of health systems supported

Sub-IR 3.1: Capacity of provincial government health systems supported

Activities and achievements

Activity 1: Strengthen the referral and counter-referral systems. Having established a referral network in both Bas-Congo and Sud Kivu in the last quarter of Year 3, the priority for Q1 of Year 4 was to set up the referral network in Katanga. The ProVIC Katanga provincial office coordinated a meeting to harmonize and integrate activities in collaboration with government HIV programs, including the PNMLS, the PNLS, and Division des Affaires Sociales (DIVAS). Fifty stakeholders attended, including service providers working with ProVIC and government representatives from the ten health zones where ProVIC is active. All were briefed on the HIV referral network, particularly the use of tools, the reporting system, and the follow-up mechanism. The follow-up mechanism is based on ProVIC's support of a monthly monitoring meeting at the health zone level involving community actors and health service providers.

In Kinshasa, 325 service directories were reproduced; these will be distributed in Q2 and the referral network will be reinforced. Other tools such as the referral and counter-referral forms are available in all settings except Kisangani. In Katanga, the referral directory was updated to include NGO services in the CCs. The development of Kisangani's HIV service directory was postponed to the next quarter following guidance from USAID that this activity should be coordinated by ProVIC rather than a local consultant.

Activity 2: Support the government's supervisory role at all levels. ProVIC supported the organization of monthly monitoring meetings for health zones in Kinshasa, Sud Kivu, Katanga, and Kisangani. In Katanga, it supported 21 monitoring meetings across seven health zones (Kampemba, Kenya, Sakania, Panda, Kikula, Lubumbashi, and Kipushi).

Activity 3: Support leadership-building activities within programs. No specific sub-activities were planned for Q1.

Activity 4: Build the capacity of health care providers. In Bas-Congo, training on an integrated HIV package of services was organized in collaboration with the PNLS for 40 health service providers drawn from 18 health centers in six health zones. Three health systems strengthening training sessions were organized in Katanga. Additionally, 30 service providers were trained in biomedical waste management, and 75 community workers were trained in two new champion communities on sensitizing the community on key prevention messages focusing on TB and HIV.

ProVIC supported health staff from the Luisha health center to participate in the integrated HIV/AIDS training organized primarily for health workers in Fungurume under the PATH GDA with Tenke Fungurume Mining. This training allowed the Luisha health center to become an ART site.

Activity 5: Support commodity management in the health zones. In Bas-Congo, 13 facilities received a follow-up visit from ProVIC's logistician and pharmaceutical supplies expert, who provided support on commodity management. This visit aimed to reinforce the capacity of service providers in commodity management, and refresh their knowledge of warehouse management.

Activity 6: Support the PNMLS in development of standards and guidelines. No activity was planned for this quarter.

Activity 7: Reproduce and distribute tools. Planned for Q2.

Activity 8: Conduct integrated supervision. During Q1, ProVIC designed the integrated checklist which will be used for this activity to enable supervision/evaluation of integration across ProVIC's services within each Champion Community. This will be piloted and launched in Q2.

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Lack of availability of the government counterpart to achieve some activities, due to their reporting period.	Postpone some activities until the next quarter.
Local consultant not accepted to develop the service directory in Kisangani.	Complete, but with a delay of one quarter.

Challenge	Proposed solution
Need to provide integrated HIV training for new service providers in Kisangani.	Hold discussions with FHI 360 (USAID partner) to plan for this training.

Sub-IR 3.2: Capacity of nongovernmental organization partners improved

Activities and achievements

Activity 1: Strengthen the organizational capacity of partner NGOs. In Q1 of Year 4, the focus of the new Health Systems Strengthening Capacity-Building Specialist was to familiarize himself with and provide support to the six grantees in Kinshasa and four grantees in Katanga. This was achieved by reviewing the previous organizational capacity assessments conducted in February 2012 and conducting an inventory of the NGOs' procedural manuals and strategic communications and resource mobilization plans.

The Health Systems Strengthening Capacity-Building Specialist reviewed the progress made by the partners on developing these administrative and financial policies and documents, and provided a framework of the procedural manual and further guidance to partner managers. Three partners—AMO-Congo, Progrès Santé Sans Prix (Progress and Health Without a Price), and Réseau National des Organisations d'Assise Communautaire (RNOAC, a national network of community-based organizations that assists PLWHA)—have made clear progress, while TIFIE Humanitarian, the Society for Women and AIDS in Africa (SWAA), and Fondation Femme Plus (FFP) have started updating their manuals but require further support. In Katanga, standard models of strategic plans and procedural manuals were discussed with the managers of OLASEC, Kolwezi Bureau Diocésain des Œuvres Médicales (Diocesan Bureau for Medical Research), and BAK-Congo. The NGOs will finalize their procedural manuals in the next quarter for validation by their Council of Administration or General Meetings. Further visits by the specialist will be made to the NGOs in the remaining three provinces in the next quarter.

The Health Systems Strengthening Capacity-Building Specialist assisted the ProVIC finance team with developing a checklist and monitoring the partners in their use of QuickBooks, which was installed by ProVIC in Year 3. All the partners are effectively employing QuickBooks, and it is expected that the grantees' Q1 financial reports will be produced using this software.

Overview of Q1 data

PEPFAR Indicator	Year 4 Annual Target	Year 4 Q1 Achievement					
		Bas Congo	Katanga	Kinshasa	Province Orientale	Sud Kivu	Year 4 Q1 Total
Sub-IR 3.2: Capacity of nongovernmental health providers improved							
H2.3D Number of health care workers who successfully completed an in-service training program		40	40				40
	PMTCT	N/A					0
	Outreach with general population (sexual prevention)	N/A					0
	Male circumcision	N/A					0
	Injection safety	N/A					0

Blood safety	N/A						0
Intravenous and non-intravenous drug use	N/A						0
Testing and counseling	N/A						0
Adult care and support	N/A						0
Adult treatment	N/A						0
Pediatric care and support	N/A						0
Pediatric treatment	N/A						0
TB/HIV	N/A						0
Laboratory infrastructure	N/A						0
Strategic information	N/A						0
Other (please specify)	N/A						0

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Ensuring that partners do not just have strong procedural manuals but are compliant with them as well.	Assess the level of application of procedural manuals through biannual evaluations.
Strengthening the institutional autonomy of NGO partners.	Encourage NGOs to work within the “program” approach rather than the “project approach.”
	Strengthen the managerial capacity of team leaders.
	Develop modern management tools.

Sub-IR 3.3: Strategic information systems at the community and facility levels strengthened

Activities and achievements

Activity 1: Strengthen ProVIC’s M&E system through ongoing coordination with other technical areas. ProVIC’s provincial M&E Officers continued to conduct monthly site visits to ensure the availability and correct use of data collection tools and datacards; to monitor the Local Capacity Development approach in Kinshasa; and to conduct routine data quality audits (RDQA).

M&E systems strengthening activities during the reporting period also included a refresher training workshop with PMTCT health providers. ProVIC’s National Pediatric Specialist, provincial M&E Officers, and health zone chief medical officers explained the completion of the project’s new PMTCT data collection tools.

To improve TB screening results and the early placement of PLWHA on TB treatment, ProVIC’s care and support and M&E teams provided grantees with a tool to improve the identification of active TB cases. With the help of this tool, 40 percent of all PLWHA were screened for TB in both community- and facility-based settings among ProVIC-supported PLWHA during the first quarter of Year 4.

As part of Kisangani expansion activities, 25 representatives from ProVIC health facility and NGO partners in Kisangani were trained in October 2012 on the use of data collection and reporting tools, with technical support from the PNMLS and PNLS. In collaboration with the provincial

BCP/PNLS and PMTCT and HCT service providers, data collection tools and reporting templates were provided to all seven ProVIC-supported health facilities in Kisangani.

Activity 2: Provide technical assistance for M&E activities to the PNMLS, PNLS, and MINAS at the national and provincial levels. No meetings with the PNMLS M&E Task Force as specified in ProVIC's Year 4 Work Plan were convened during the first quarter of Year 4. However, ProVIC's Kisangani M&E Officer convened joint supervision briefings with the provincial government and local implementing partners to promote strong relationships with these newer provincial-level partners. The project's National M&E Specialist and Kinshasa M&E Assistant also contributed to collaborative efforts to amend the terms of reference of the DRC government's Task Force on Maternal, Newborn, and Child Health.

Activity 3: Strengthen MINAS' M&E systems through joint missions and technical assistance in developing a national OVC database. ProVIC helped launch an OVC identification tool and national database during the reporting period in collaboration with DIVAS and FFP.

Activities 4 and 5: Build implementing partners' M&E capacity, including through the peer-to-peer capacity development approach. As part of ProVIC's efforts to scale up peer-to-peer local M&E capacity development activities launched in Year 3, the project's Kinshasa M&E team supervised C2C group facilitation activities led by SWAA in the Champion Community of Mafuta Kizola and monitored implementation of the approach by SWAA and RNOAC.

Activity 6: Improve implementing partners' capacity to conduct quality improvement activities and provide high-quality services (as described in Sub-IR 1.3, beginning on page 3). In December 2012, ProVIC, in collaboration with the PNLS and a consultant from URC, organized a three-day training workshop on quality assurance of health services. All of ProVIC's national technical specialists, as well as the project's Kinshasa and Sud Kivu M&E staff, participated in the workshop, which developed their ability to implement the Improvement Collaboratives approach, which has been successful for PEPFAR partners in other countries.

As a first step in establishing Improvement Collaboratives, a coaching team comprised of ProVIC's Kinshasa M&E team and representatives from the PNLS, the PNSR, and local partners was established to help pilot the approach in four ProVIC-supported PMTCT facilities in Kinshasa. The results of this four-site pilot will inform scale-up of the approach to additional ProVIC sites.

Activity 7: Provide ongoing datacard technical support to implementing partners to improve M&E reporting. In follow-up to a Year 3 project review, the M&E team convened a data-reporting workshop with ProVIC's national technical leads in order to identify and address datacard concerns and challenges experienced during the course of the year. This feedback is currently being collated, along with technical feedback received from USAID over the past few months, into datacard revisions anticipated to be made with the support of PATH's database consultant during the second quarter. ProVIC also hopes to have this database consultant lead a one-week workshop in Kinshasa in Q1—both to debrief ProVIC's M&E and national technical staff on the datacard revisions and to provide capacity-building support to ProVIC's M&E and other technical staff to creatively use data routinely generated by ProVIC's Salesforce database. The updated datacards

will also be disseminated to all of ProVIC's local partners, who will in turn be oriented on these revisions.

In Q1, ProVIC facilitated work plan review and planning workshops in Katanga, Sud Kivu, and Bas-Congo, aimed at reviewing both Year 3 results and achievements and Year 4 targets—a critical coordinated planning activity. These provincial workshops included participation from key government stakeholders (e.g., representatives from the provincial ministries of health, Central Health Zone Bureaus, PNMLS, PNLs, and DIVAS), as well as key USAID and other implementation partners, and served to importantly secure key DRC government stakeholder buy-in for ProVIC's Year 4 Work Plan. Participation from this diverse stakeholder group also helped secure the commitment of Central Health Zone Bureaus to begin monitoring health service delivery activities of ProVIC-supported communities this project year.

Activity 8: Improve reporting through RDQA. A ProVIC-led data quality assurance session with FFP's Kisangani team was conducted. The data audit focused on improving data collected for PEPFAR Next Generation Indicator P8.3D (number of MARPs reached with individual and/or small group-level interventions that are based on evidence and/or meet the minimum standards), for which ProVIC helped FFP develop a priority action plan to address two identified data quality issues: the use of outdated awareness-raising session attendee lists and summary reporting sheets/tools.

Challenges during the reporting period and proposed solutions

Challenge	Proposed solution
Increased number of PEPFAR Next Generation Indicators to regularly track and report.	Update data collection tools to account for new PEPFAR Next Generation Indicators (e.g., C2.4D, T1.1D).
	Revise/Update datacards to incorporate newly added PEPFAR indicators.
	Train ProVIC staff and local partners on proper data collection and reporting for newly added PEPFAR indicators.
Weak organization/management of OVC M&E activities by MINAS and DIVAS.	ProVIC is now coordinating with CapacityPlus, a new USAID partner which is also focusing on capacity-building for MINAS and DIVAS.
Lack of required data collection tools among new PMTCT Acceleration sites.	Continue datacard training in Q2 for new PMTCT sites.

Activities planned for the next quarter for Intermediate Result 3

Sub-IR 3.1 <i>Capacity of provincial government health systems supported</i>	Sub-IR 3.2 <i>Capacity of NGO partners improved</i>	Sub-IR 3.3 <i>Strategic information systems at the community and facility levels strengthened</i>
Strengthen the referral and counter-referral systems.	Support grantees in all provinces in the finalization of organizational and policy documents (e.g., procedural manual).	Revise datacards to include new ProVIC care and support activities being integrated at the health facility level.
Support the government's supervisory role and leadership-building activities at all levels.	Organize a workshop on governance and administration for the 14 grantees.	Train new PMTCT partners on datacard use.

Program management update

Staffing

The Katanga M&E Officer suffered a serious medical condition and was evacuated to Kinshasa for rehabilitation, where he is improving now (ProVIC will keep USAID updated on his progress). However, it will be many months before he is able to return to his post. ProVIC has requested authorization to hire a second M&E Officer in Katanga, also justified by the increased workload in the province. Mr. Hippolye Mwakanzal, the new NGO Capacity-Building Officer, was also hired in Q1.

Security issues

In Q1, the unexpected fall to rebels of the town of Goma in Eastern Congo triggered a series of ProVIC security strengthening actions, including repositioning of non-Bukavu staff visiting the Bukavu office, and the provision of short-term technical assistance from a Chemonics International security officer, who conducted situational analyses in Kinshasa, Bukavu, and Kisangani to review security risks and provide recommendations going forward. These recommendations are being implemented now. ProVIC will submit a supplementary security budget request in Q2.

Quarter 1 environmental monitoring and mitigation activities

Activity	Potential negative environmental consequences	Status report
HCT	HCT generates biohazardous health care waste such as syringes and other hazardous sharps, which if not disposed of properly are a health risk for those who come in contact with them. It also requires drawing blood, which must be then properly stored and disposed of.	<p>All HCT and PMTCT sites have received training on waste management and regularly receive supplies (waste receptacles, cleaning supplies), and either have incinerators or have project funds available to correctly dispose of environmentally hazardous waste.</p> <p>All normative documents have been shared, including national policy, job aids, and guidelines and reporting templates for environmental protection.</p> <p>30 health workers in new HCT, PICT, and PMTCT Acceleration sites have been trained on medical waste management. These include one doctor, 11 nurses, 8 laboratory technicians, 7 managers, 2 community workers, and 1 assistant nurse.</p>
PMTCT	PMTCT includes HCT and therefore the risks mentioned above. In addition, the labor and delivery process includes the use of syringes, needles, and other sharps. It also necessitates a way to remove the blood and other bodily fluids and clean and decontaminate the delivery area to prevent contact with potentially hazardous fluids.	<p>ProVIC provided refresher training for providers in 35 existing PMTCT sites and identified training needs in six new sites in Kisangani.</p> <p>The project upgraded incinerators in 16 existing PMTCT sites and identified needs in 26 new sites.</p> <p>All PMTCT sites have adequate equipment to dispose of waste safely (sharps boxes, safe pits or burial sites, or facilities for incineration or other safe disposal).</p>
Palliative care	Palliative care for PLWHA includes, as discussed above, both the use of hazardous sharps and exposure to bodily fluids which may be infectious.	Community health workers have been trained and receive appropriate supplies for home visits.